fallon community health plan

One Chestnut Place ■ 10 Chestnut St. ■ Worcester, MA 01608 ■ 508-799-2100

74361

May 27, 2010

David Morales, Commissioner
Division of Health Care Finance and Policy
2 Boylston Street, 5th Floor
Boston, MA 02116

Re: proposed regulations:
114.5 CMR 21.00 (Health Care Claims Data Submission)
114.5 CMR 22.00 (Health Care Claims Data Release)

Dear Commissioner Morales:

I am writing on behalf of Fallon Community Health Plan (FCHP) with comments on proposed regulations 114.5 CMR 21.00 and 22.00, concerning the All Payer Claims Database (APCD). We appreciate the opportunity to offer our comments on these important regulations for your consideration.

In implementing the APCD, the Division intends to consolidate what are currently several distinct data reporting requirements, creating a more comprehensive state health care database. This is a worthy goal, and we support the Division's efforts towards administrative simplification and transparency. We believe that the APCD offers a very real opportunity for progress in these areas.

We have concerns, however, that the October timeline proposed by the Division is not feasible. Beyond the ability of insurers to operationalize the new reporting format, it is unclear at this time whether other state agencies whose data reporting is to be included in the APCD are on board with the project. The absence of those agencies' data reporting from the APCD would greatly diminish its administrative advantages. There also remain a number of ambiguities and loose ends around provisions of the regulations. For example, it is unclear what privacy and confidentiality provisions will govern data submitted to the APCD, and under what authority data for self-funded and Medicare Advantage plans is to be collected. The process would benefit from additional time to tie up these matters.

Timeline

The proposed regulations call for data reporting under the APCD format to begin by October 15, 2010. Implementation will involve not only integrating a number of existing files, but adding additional fields and files, some involving data that we do not currently collect. Based on the availability of staffing and financial resources, we have severe doubts that it is feasible for FCHP to meet the above timeline.

In FCHP's case, our ability to complete the project is further hampered by ongoing work on the conversion of our core IT system. While most functions were converted to the new system in March, many IT resources are tied up in followup work or in completing projects (many of them driven by regulatory requirements) which have been waiting for the main conversion to take place. Absent the system conversion project, in a best-case scenario, it would be difficult for APCD implementation to be completed any earlier than the beginning of 2011. With the system conversion project in place, the second quarter of 2011 is likely a more realistic timeframe.

Buy-in from Affected State Agencies

The proposed APCD would combine insurer data reporting currently done to a number of different state agencies, including the Division itself, the Health Care Quality & Cost Council, MassHealth, the Connector, and the Group Insurance Commission. We support this concept and believe that the APCD offers a very real opportunity for meaningful administrative simplification.

We have concerns, however, that MassHealth and the Group Insurance Commission have not yet signed off on the use of the APCD for their data reporting requirements. (Indeed, testimony given by the Group Insurance Commission at the May 17 public hearing on 114.5 CMR 21.00 indicates that the Commission has its own concerns with the APCD.) Without the participation of these agencies, the APCD's positive impact is greatly diminished. The end result could actually be the opposite of what is intended – greater administrative burden and expense, due to the need to maintain multiple reporting platforms, at a time when the focus should be on keeping costs under control. For the APCD to serve its purpose, all relevant state agencies must make a commitment to use it.

Open Questions

A number of open questions remain with regard to various provisions of the proposed regulations. Broadly speaking, it is not always clear what statutory authority the regulations operate under. The regulations reference M.G.L. Chapter 118G, but much of the data is currently submitted under requirements that do not derive from that chapter. If data is being submitted under the authority of the Health Care Quality & Cost Council or MassHealth, what privacy and confidentiality requirements apply (an important question, given the personal health data and competitively sensitive financial data to be included in the submission)? If an insurer fails to submit files in a timely manner, what penalties apply? To what extent, if any, will MassHealth and the Group Insurance Commission have access to data beyond what they receive from insurers today?

We also have concerns with the requirement that insurers submit data for Administrative Services Only (ASO) and Medicare Advantage members. We do not currently include these members in our Health Care Quality & Cost Council reporting, and would question the propriety of doing so. Data for ASO groups truly

belongs to the group, not to insurers acting as third party administrators. Data for Medicare Advantage members is under the authority of the federal Centers for Medicare and Medicaid Services (CMS). We have not yet seen any indication that CMS is on board with the inclusion of Medicare Advantage data in this reporting.

Another potential issue involves Section 22.04(2), which allows applicants of the data to release the information back to the payer so that the payer can verify the accuracy of the data. Would payers be required to perform this validation? This could impose an administrative burden on plans to have to validate the accuracy of the data with every entity that requests it.

Privacy and Security

Among the items referenced in the previous section, we are especially concerned with the regulations' handling of privacy and security, and wish to offer specific suggestions on how this matter should be addressed . The regulations do not fully outline the privacy and security requirements that the Division must follow in maintaining this data. Furthermore, the regulations do not provide enough specificity around who will be able to have access to the data, both the public data and the restricted data, what requirements they must meet in order to have access to the data, and what privacy and security standards to which they will be held.

We recommend clearly defining the different categories of data and the purposes for which external entities can access each and the requirements that must be met in order to be permitted that access. We recommend that these requirements closely mirror the HIPAA Privacy and Security Regulations, since these are the requirements each payer would need to follow if those same entities were to request the data directly from the payer.

We recommend the following categories:

1) Public Data should be deidentified according to the HIPAA Privacy Regulations. This means that all dates related to the member (e.g. paid date, enrollment start date, enrollment end date, PCP effective date, PCP termination date, date service approved, date prescription filled, paid date, etc.), all unique identifiers (e.g. claim control number, member ID, etc.), and any geographic subdivision smaller than state must be removed.

   While not required by HIPAA Privacy, all proprietary information (e.g. allowed amount), provider identifying information, and plan identifying information should be removed.

   Since this information would not be protected or governed by any regulatory requirements, it could be relatively accessible for anyone who shows a need for the information and that use of it would serve a public purpose.

2) Restricted Data should be nothing more than a limited data set as defined by the HIPAA Privacy Regulations. This means that dates related to the member and town, city, state, and zip code could be included.

   While not required by HIPAA Privacy, all proprietary information, provider identifying information, and plan identifying information should also be removed.

   Access by external parties to this information would only be permitted under the circumstances in which a covered entity could disclose a limited data set under HIPAA Privacy. It must be for research or public purpose and the recipient must sign an agreement whereby they attest to all the elements that must be included in a data use agreement. Additionally, the recipient would be required to follow the HIPAA Security regulations in the storage and access to that data.

3) Regulatory Data is all the data submitted by the health plans. This includes all the member identifiers, proprietary data, and plan information.

   This data would only be accessible by governmental agencies that are permitted/required access to the data pursuant to some duly enacted statutory provision.

Conclusions

While the APCD has the potential to be a valuable project, the current timeline is too aggressive, and leaves too many questions and policy decisions unresolved. We urge the Division to hold off on finalizing the regulations until these matters can be addressed, and to look towards a 2011 implementation date.

We appreciate your consideration of our comments. If you have any questions or need any additional information, please do not hesitate to contact me at 508-368-9499.

Sincerely,

Charles R. Goheen
Executive Vice President & Chief Financial Officer
Fallon Community Health Plan, Inc.